

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2023
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NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 400 W SEVENTH ST NORTH MANCHESTER, IN 46962
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00414874, IN00415238 and IN00415053.</p> <p>Complaint IN00415238 - Federal/state deficiencies related to the allegations are cited at F919.</p> <p>Complaint IN00414874 - No deficiencies related to the allegations were cited.</p> <p>Complaint IN00415053 - No deficiencies related to the allegations were cited.</p> <p>Survey dates: August 22 and 23, 2023.</p> <p>Facility number: 000485 Provider number: 155655 AIM number: 100291190</p> <p>Census Bed Type: SNF/NF: 161 Residential: 61 Total: 222</p> <p>Census Payor Type: Medicare: 9 Medicaid: 96 Other: 56 Total: 161</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed August 29, 2023.</p>	F 0000	<p>It is the policy and practice of Peabody Retirement Community to be adequately equipped to allow residents to call for staff assistance through a communication system. Peabody Retirement Community call system relays the resident call directly to a staff member via pager AND a centralized staff work area from each resident's bedside, toilet and bathing facilities and person -if in the event they are using a pendant- going beyond regulation requirements.</p> <p>The following is entered per regulation and is not an admission of fault or wrong-doing on the part of the community.</p>	
F 0919 SS=F Bldg. 00	<p>483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-</p> <p>§483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. Based on observation and interview, the facility failed to ensure the call light system was operational. This deficiency had the potential to effect 161 of 161 residents living in the facility.</p> <p>Findings include:</p> <p>During an interview on 8/23/2023 at 10:17 a.m., the Administrator indicated between 8/10/2023 and 8/15/2023, the call light system had been worked on. After the call system technician left, it was discovered the call lights were not transferring to the pagers (used to alert staff). The facility started doing 15 minute rounding on the residents. The call system technician was called and an attempt to trouble shoot over the phone was made. The Administrator indicated she checked the call lights and found the system functioned sporadically. The next day, the call system technician returned to the facility at 9:00 a.m., and discovered the resident's call pendants were not working. The 15 minute rounding continued. The call system technician reprogrammed the equipment. The facility was rounded on at 9:30 a.m. and the call system was working.</p> <p>During an interview on 8/23/2023 at 10:21 a.m., the Maintenance Supervisor indicated the call light system was working. On 8/15/2023 and 8/16/2023, the call system technician told the facility the transmitter was not working. It had been replaced,</p>	F 0919	<p>It is the policy and practice of Peabody Retirement Community to be adequately equipped to allow residents to call for staff assistance through a communication system. Peabody Retirement Community call system relays the resident call directly to a staff member via pager AND a centralized staff work area from each resident's bedside, toilet and bathing facilities and person -if in the event they are using a pendant- going beyond regulation requirements. Peabody Retirement Community requests an IDR for this deficiency on 2 basis. First 87 of 161 residents are capable of and choose to utilize pendants that they wear on their person. Second, our call light system utilizes both a centralized work area display as well as pagers that are worn by the CNA's on duty. During the survey our centralized work area call light communication display did not fail to operate. The centralized work area display function, and continues to function, completely and continuously. Please see the</p>	09/08/2023

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	<p>but was found to be defective out of the box. The signal was too weak to be picked up. There was a report that indicated if a unit (pendant) needed new batteries and the report is viewed at least weekly.</p> <p>During a facility tour on 8/23/2023 at 2:06 p.m., CNA 1 and CNA 2 activated pendants for 3 residents. The activation should have triggered a notification on the pagers the CNAs were supposed to be carrying. After 10 minutes, one resident notification displayed on the pager, and the other two never displayed on the pagers.</p> <p>During a facility tour on 8/23/2023 at 2:21 p.m., the Administrator and the Director of Facility Services indicated the call light system had been worked on recently and was believed to be functional. The Administrator, Maintenance Director, and Director of Facility Services conducted call light checks for several resident rooms, bathrooms, and pendants. The bathroom and room call lights activations were displayed on the pagers. The pendant signals were not consistently displayed on the pagers. The Administrator indicated if the pagers or call lights were not functioning properly, staff should have informed them.</p> <p>During an interview on 8/23/2023 at 2:44 p.m., CNA 4 indicated she was not carrying a pager because she was told they were not working. The CNA indicated she had been on the unit since 6:00 a.m. and was told to watch the monitor to see what call lights had been activated because the pagers were not working.</p> <p>During an interview on 8/23/2023 at 2:57 p.m., the Administrator indicated staff had not reported the call lights were not consistently operational.</p>		<p>attached letter for further detail.</p> <p>1. Peabody Retirement Community respectfully disagrees with the potential to affect 161 out of 161 residents living in the facility. During said survey dates, only 87 residents have the capability of using the call light pendant.</p> <p>Furthermore, Peabody Retirement Community has an alternative method of communication to the call light system pagers. The community has monitors located in each centralized staff work area on each unit that includes visual and audible alerts. These centralized monitors continued to function during the survey dates in question. As survey report indicates, all staff are reminded to review said monitors for pages throughout the shift.</p> <p>Prior to the survey date, on 8/10/23, the call light system was noted to not be transmitting alerts to the pagers consistently, although the calls continued to go to the centralized monitor. The maintenance manager and administrator worked with Palcare via telephone to try and resolve the issue. On 8/15/23, a technician was dispatched to the facility to work on the call light system. After the technician left the facility at approximately 1:40 pm, the calls were no longer transmitting to the pagers or the monitors. The Administrator notified the</p>	

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	<p>Confidential interviews were completed during the survey.</p> <p>During a confidential interview, an employee indicated the call light system had been working intermittently for several days. "It is a hit or miss."</p> <p>During a confidential interview, an employee indicated it was hard to know when residents had their call lights on because they had to go to the nurses station to look at the monitor. The monitor had been turned so it could be viewed from the common area.</p> <p>No alternate means of alerting staff were observed during the survey.</p> <p>Review of a current facility policy, dated January 2004, titled "Emergency Call System-Guardian" indicated the following: "...Policy: It is the policy of Peabody Retirement Community to provide an effective emergency call system to assure appropriate response to residents in licensed areas (Health Care & Memory Enhancement Center). Procedure: 2. Each resident will be assessed to determine their physical and cognitive ability to be offered a portable "alarm button - i.e. pendant" that can be worn on their person giving them access to the call system in any location inside or outside of their room. 3. The "pendant" will be programmed with the resident's name and room number. 4. When a resident activates the pull cord or pendant, the wireless signal will be sent to the pagers carried by staff (Resident Services Coordinators and the Clinical Staff Nurse) in the resident's neighborhood indicating which resident and their location."</p>		<p>technician that pagers on HCS, Rebab and Magnolia Lane were not transmitting, and that pages were being transmitted sporadically on HCN and in the Peabody Inn (Assisted Living). The nursing staff initiated 15-minute rounding on resident care areas. Alert and oriented residents were given a bell to ring if assistance was needed. The maintenance manager tried to work with the technician to resolve the issue over the phone but was unsuccessful. The technician returned onsite on 8/16/23, where he met with the Administrator, DON, and the Facility Operations Director at 9:00AM.</p> <p>Fifteen-minute rounding continued. The technician explained that the transmitter that had been previously replaced was defective out of the box and the signal was too weak to pick up. When he reprogrammed the new piece of equipment on 8/15/23, it put the other pieces of equipment offline. He stated that their offsite technical support identified the issue and was able to bring the other pieces of equipment back up and online at 5:30 AM on 8/16/23. At approximately 930AM that morning, the nursing managers went out to all areas of the campus to test the pagers and pull cords to ensure they were coming through the system correctly. The call system was</p>	

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	<p>This Federal tag relates to complaint IN00415238.</p> <p>3.1-19(u)</p>		<p>functioning at that time. This event and follow up were reported to the ISDH via the ISDH Gateway. During the survey, the centralized monitor continued to function and displayed all pull cord and pendant calls. At the time of the survey, the maintenance manager and administrator called the technician and explained the delay of the pendant calls going to the individual pagers. The technician advised us to install a booster near the neighborhood to assist with the signal. At approximately 4:00pm a signal booster was installed near Health Care South, each neighborhood was tested with successful communication from the pendant to the pagers. At no time did the centralized monitor stop displaying the pendant or pull cord calls.</p> <p>2. Out of abundance of caution, alert and oriented residents who use the call light system were interviewed to determine effects from the alleged deficiency. A portion of families were interviewed on behalf of those residents who are not alert and oriented. No residents or families verbalized distress or concern at this time regarding the call light system. A routine resident council meeting was held with guest, Dana Neer Ombudsman, in attendance on 8/23/23. The call light system was not discussed as a concern during that meeting.</p>	

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			<p>There have been no concerns voiced by residents via our grievance process after 8/16/23.</p> <p>3. As mentioned, Peabody Retirement Community will remain adequately equipped with a call system which relays the resident call directly to a staff member via pager AND a centralized staff work area from each resident's bedside, toilet and bathing facilities and person -if in the event they are using a pendant- going beyond regulation requirements. All staff in-serviced, including agency, on aforementioned policy emphasizing to continue to check monitor and pagers for call light alerts.</p> <p>4. Auditing of the site summary report reveals continued timely responses since 8/10/23. Don, or designee, will continue to audit at various times and locations the 1) summary report, 2) test six (6) call lights and 3) perform six (6) interviews – one (1) time daily, 5 days a week, for 1 month then; will audit at various times and locations the 1) summary report, 2) test six (6) call lights and 3) perform six (6) interviews – one (1) time a week, for five (5) months. Results of these audits will be forwarded to Qapi. Any negative findings will add an additional month of auditing until 100% compliance is achieved.</p> <p>5. Date of compliance 9/7/23.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-039

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